By Dental Tribune International

HELSEINKI, Finland: The Royal Technology Mission, with His Majesty King Carl XVI Gustaf of Sweden as its patron, visited Finnish health care technology manufacturer Planmeca in Helsinki on 27 November. His Majesty, along with 50 other top representatives of Sweden’s government, private sector and academia, learnt about the company’s growth story and innovations.

The Royal Technology Mission visited Finland to gain inspiration from the country’s innovative companies, initiatives and growth strategies. At Planmeca, the mission was introduced to revolutionary 3x3D technology, patient-specific 3-D implants, and the dental unit-integrated intra-oral scanner Planmeca PlanScan. Planmeca is one of the

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King of Sweden introduced to new standard of dental technology at Planmeca

The Majesty King Carl XVI Gustaf of Sweden (left) shaking hands with Heikki Kyöstilä (right), President of Planmeca. His Majesty visited Finland for inspiration from innovative companies such as the dental market leader. (Photographs: Planmeca)
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Sirona – The Dental Company shines in Dubai

By Sirona

DUBAI, UAE: Sirona Middle East was again at the center of attention at the 19th International Dental Conference & Arab Dental Exhibition in Dubai between 17-19th February 2015. The Dental Company exhibited with a specially designed booth conducting ongoing trainings and presentations given by Sirona staff, CEREC trainers and Key Opinion Leaders including the infamous Dr. Daniel Vasquez, USA. Dr. Vasquez also presented at last year’s CEREC Desert Fest in Dubai.

Sirona will soon enter a new milestone in the Middle East region where a direct operation and dedicated dealership will work together on bringing an optimal support bringing the sales and services of The Dental Company to a higher level compared to the rest in the industry. We presented the model to our customers during the International Dental Conference & Arab Dental Exhibition in Dubai and we expect a market service boost in the years to come.

After the successful CEREC Desert Fest in September last year we brought back Dr. Daniel Vasquez (USA) who is an icon in presenting CEREC to new customers. With his unique appeal in detailing the product to audiences Dr. Daniel provided several hands-on presentations at the trade show in front of interested potential and existing customers. The presentations showed the ease of using CEREC and how it is the CAD/CAM application which should be used in dentistry for the present and future.

Recently Sirona launched yet again a new system, providing a freedom of choice with the MCX 5. The new InLab system will have a big impact on the CAD/CAM lab business. The product was officially launched in the Middle East in February and the feedback was above expectations. The smart compact designed five-axis milling and grinding unit is especially developed for the demands of the dental laboratories completing Sirona’s InLab system. Dental Technicians will now benefit from the great flexibility for the entire production process of aesthetically pleasing restorations and the largest selection of materials available on the market.

IDS Cologne 2015 – the Mondial of the Dental Industry is set to begin on 10th March and Sirona will bring all the new products to the marketing boosting the industry with different product lines such as Imaging and CAD/CAM systems, Treatment Centers and Instruments.

Sirona will continue to grow worldwide and in the Middle East region which will be shown through our core built on Education in our products which we produce for the dental industry. We are in a sector of our society that has built careers on knowledge and product understanding in order to deliver the best treatment to their patients. Sirona aims to always be in the background of our customers and supply them not only with the technology but the know-how behind the fast changing industry. This has been and will continue to be achieved through well maintained high level continuing dental education programs ensuring the long term continuity of our customers’ business.

Dr. Daniel Vasquez, USA – presented various lectures and hands-on presentations on stage

Sirona booth was at the center of attention during the trade show in Dubai

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Immediate implantation and provisionalization: Single-tooth restoration in the esthetic zone

By Susan McMahon, DMD and Karrah Petruska

A nterior tooth loss and resorption in the esthetic zone as a common challenge in dentistry today. The prominent visibility of the area can especially distressing to the patient and requires a timely and esthetically pleasing solution.

Immediate single-tooth implantation followed by immediate provisionalization is becoming an increasingly desirable treatment modality that offers numerous benefits over conventional delayed loading.

In the past, the non-restorable tooth was extracted and possibly grafted for site preservation. A removable partial denture (or flipper) was fabricated and placed for use during healing. After an adequate healing period, an implant was placed and buried under the gingiva, and the patient continued to wear the flipper until the implant had osseointegrated and was ready to be uncovered and restored. The patient would therefore wear the removable partial denture for upwards of six to eight months.

This course of treatment often results in undesirable esthetic changes to the gingival architecture surrounding the final restoration. There are also clear indications that partial removable dentures are an important causative factor in the alveolar bone resorption process.

Today, immediate treatment offers a better solution. Immediate implantation and same-day provisional replacement of a single anterior tooth minimizes treatment time and cost while enhancing esthetic quality. In addition to alleviating patient trauma, this technique decreases resorption of hard and soft tissue and results in better function.

Overall, this leads to greater patient satisfaction.

In this process, the implant is placed and provisionalized quickly. A nonfunctioning, also known as non-cemented, provisional is used in a protected occlusal scheme. The placement of the non-occlusal restoration must occur within 48 hours to be considered immediate loading. Both of the following cases received same day provisional crowns.

The clinician faces several challenges when restoring teeth in the esthetic zone. Major cosmetic concerns in the fabrication of the immediately placed provisional are the retention of the interdental papilla and prevention of alveolar bone collapse. Research has suggested that immediate provisionalization following implantation allows for greater clinical control over the regeneration of tissue surrounding the site of extraction.

Unfavorable alterations to the alveolar bone structure must be avoided using ridge preservation techniques and precautions in terms of osseous exposure. Immediate placement of the implant into fresh extraction sockets prevents the post-extraction resorption that occurs commonly with alternative forms of treatment, preserving the integrity of the alveolar ridge. A compromised implant site is also a concern when dealing with tooth loss. Bone resorption may leave insufficient bone for implantation. Furthermore, a detritivated bone surface in an alveolar socket produces an inferior interior. Immediate implantation into the fresh extraction socket allows the clinician to maintain the gingival tissue and create a more esthetically pleasing restoration.

Minimum criteria for implant placement have been established for successful immediate loading. Rough quantities values for insertion torque and implant stability quotient (ISQ) as well as surgical assessment play a role. Values as low as 15N-cm for insertion torque and 50 ISQ both result in successful provisionalization.

Additionally, the surgeon must assess where there is adequate bone support at the apex, at least 5 mm of circumferential bone, and primarily stability of the implant. Research has shown that “early loading of dental implants does not appear to interfere with osseous modeling of a developing bone” and surgical prediction of a successful osseointegration, a final restoration.

Case study 1: failing maxillary right central incisor

The patient is a 50-year-old healthy male who was examined in our office for a failing maxillary right central incisor. His history includes a soccer accident in 1995 that resulted in an elbow to the face with trauma to the right maxillary central incisor. Approximately one week subsequent to the accident, the patient’s tooth was treated endodontically. It eventually became discolored and grew increasingly out of alignment (Fig.1). Radiographic examination revealed internal resorption.

Clinically, all other maxillary and mandibular teeth were in good condition. Periodontal examination revealed healthy gingival tissue. The patient was concerned that his anterior tooth would fracture unexpectedly and desired an immediate replacement.

Treatment options

Several treatment options were considered. The first was extraction of the maxillary right central incisor and fabrication and placement of a conventional fixed bridge of porcelain fused to metal or an all-ceramic system. The second option was extraction of the tooth followed by placement of a removable partial denture. The next option was extraction, provisionalization with a removable partial denture (flipper) followed by implant placement, healing while wearing the flipper, and eventually restoration. The best alternative was extraction and immediate replacement of the extracted tooth with an implant, followed by immediate loading with a nonfunctioning provisional. After adequate osseointegration, a final restoration would be fabricated. Advantages and disadvantages of all options were explained to the patient. He decided to continue treatment with an immediate implant restoration. The patient was then referred to a periodontist for further evaluation and implant consultation.

Implant evaluation

Implant examination revealed adequate bone height and width for implant placement immediately following extraction of the failing tooth. A surgical date was scheduled with the periodontist for extraction of the tooth and placement of the implant. An appointment was coordinated with our office for the patient directly after the implant placement. The patient was then referred to a periodontist for further evaluation and implant consultation.

Final restoration

Six months post surgery, the patient was scheduled for placement of the final restoration. After removing the provisional crown and the immediate temporary abutment, an implant impression post was placed, radiographic verification was made to assure complete seating and a final impression was taken with a polyether impression material. Complex shade-mapping was carefully performed to match the existing contralateral natural
teeth. The provisional was then reinserted.
A Procera zirconia custom implant abutment was chosen. Zirconium implant abutments have not only been noted for their tooth-like color and esthetic appeal but also for their biomechanical properties, high load strength and intracoronal design enhancement.13 The extraordinary load strength of the zirconium is not compromised by high bending and tensile strength, and fracture and chemical resistance.13 Zirconium abutments are mechanically equivalent to their metal counterparts but boast greater biological compatibility.13 Results of a recent study provide evidence that the ceramic oxide abutments can be safely utilized in the incisor region of both the maxilla and mandible as determined by maximal bite forces in the esthetic zone.14 Due to excellent restorative properties in terms of strength and color conformity, the zirconium implant-abutment is becoming increasingly favored by clinicians for esthetically pleasing anterior implant restorations.13 A Procera zirconia crown was fabricated for this patient with Noritake CZR zirconia crown was fabricated for placement in a correct emergence profile of the implant. The patient’s treatment was similar to that of the patient in the first case study. The right central incisor was repositioned and a NobelReplace tapered Grousy (internal connection) 5.0 mm x 13 mm implant was placed. An osseous graft of dehanced freeze-dried bone was utilized to augment the surgically injured zone. The fixture received an emergence profile, healing abutment. The patient then received an immediate non-functional provisional.

Final restoration
After the six-month healing period the final restoration was fabricated. In this case, a one-piece screw-through abutment made from a Nobel Biocare Goldkaltapi Eng brapi NobelReplace (Fig. 7) was fabricated in order to obtain a correct emergence profile of the restoration due to the slightly lingual placement of the implant (Fig. 8).

The restoration was seated, and the screw was hand tightened and the screw was torqued to 55 Ncm with the maxilla and mandible. The abutment was seated, the screw was hand tightened and the screw was torqued to 55 Ncm with the maxilla and mandible. The screws were tightened and the final螺丝 was inserted and tightened in place. The final螺丝 was inserted in place with 95 Nm. The final螺丝 was inserted in place with 95 Nm.

Case study 2: fractured maxillary right central incisor
This patient, a healthy male in his late 30s, was examined in my office for the treatment of a fractured maxillary right central incisor. The patient had Feldspathic porcelain restorations on his upper central and upper lateral incisors that were placed several years ago. He had a history of trauma to the anterior teeth from a sports injury and subsequent endodontic treatment.

Recent periapical radiographs showed internal resorption in the upper incisors (Fig. 5). The patient sustained additional trauma to the maxillary right central incisor through a fall, which resulted in complete fracture of the crown (Fig. 6). The tooth was nonrestorable.

After reviewing the different treatment options, the patient decided on an immediate implant restoration. Although the maxillary left central incisor also exhibited signs of internal resorption, it was decided that treatment of that tooth would be performed at a later date. Consideration was given to the poor gingival architecture that results from placing adjacent implants in the esthetic zone. He was then evaluated by the periodontist for the surgical placement of the immediate implant for the maxillary right central incisor. The patient’s treatment was similar to that of the patient in the first case study. The right central incisor was repositioned and a NobelReplace tapered Grousy (internal connection) 5.0 mm x 13 mm implant was placed. An osseous graft of dehanced freeze-dried bone was utilized to augment the surgically injured zone. The fixture received an emergence profile, healing abutment. The patient then received an immediate non-functional provisional.

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The Nr. 1 recommendation\(^1\) from dentists is to use floss, so why aren’t more people doing so?

By Jordan

Most of us have been told by our dentist that we should clean better between our teeth. Floss is a great tool to do just this. Flossing should be an essential part of any oral health care routine. Most national Dental Associations, including the American Dental Association, recommends flossing at least once a day to achieve optimal oral health.

So why is it so important? We all want clean and healthy teeth. To get this we need to invest time each day to “brush” properly. Our teeth have 5 surfaces and only 3 of them are properly cleaned by a toothbrush. In order to remove plaque from between our teeth we need to use an interdental product. If we do not remove plaque regularly it will harden and could lead to a cavity and tartar. The area just under where two of our teeth meet is one of the most susceptible to cavities. Areas in our mouth which are difficult to get to, for example around our back molars and at the back of our teeth, also make them targets for plaque build-up and tartar.

In Scandinavia, dentists recommend that children start using floss as early as when their permanent teeth start to emerge, in other words before they are 10 years old. The American dental Association recommends that children start to floss when two teeth of their teeth touch. Parental help is advised as it is difficult for children to master the technique. Establishing this habit early and doing so on a daily basis is the best way to keep your teeth clean and your gums healthy. Flossing can also help prevent and reverse the early stage of gum disease, gingivitis.

So why aren’t more people flossing? In our research\(^1\) the three most important reasons that we came across were:

- A lot of people don’t floss because they don’t think they need to. “I have no cavities or gum disease”
- It’s a routine that is difficult to establish daily. “I don’t see the results”; “it’s boring”; “It takes too long”
- It’s not easy finding the right products. “There are a lot of choices, I don’t know which ones is right for my needs”; “I don’t like having my hands in my mouth and it’s difficult to use”
- A bad past experience stops continued use. “I don’t like that my floss shreds”; “My teeth are too tight”

Jordan has a range of quality products designed for different consumers’ needs and lifestyles. Traditional floss is very effective but for some people it can be difficult to master the technique. Research shows if you are a traditional floss user, you are loyal to this format because you feel it is the most effective. Flossers are easy and convenient to use and we see more and more people choosing this as an alternative and sticking to it. This seems to be a good tool to recruit new users.

The Nr. 1 reason why people start to use floss is still because their dentist recommended it. So keep recommending and help them find the best floss product for them.
By Beverly Hills Formula

There are many misunderstandings surrounding whitening toothpastes. We tackle the common patient misconceptions to help you confidently recommend the most suitable choice for your patients.

Although teeth whitening has become one of the most sought after cosmetic dental treatments requested by patients, not all will want to “splash their cash” on these expensive treatments, but, by the same token, they are also dubious about whitening toothpastes:

1) “Whitening toothpastes are ineffective”
In late 2012, whitening toothpaste came under scrutiny when Arm & Hammer’s Advanced whitening toothpaste advertisements were banned after it emerged that 45 per cent of users, during a four-week trial, either saw no improvement or were left with darker teeth (1). By association, many patients assume that all whitening toothpastes do not live up to their claims.

Contrary to this, it’s important that the effective toothpastes available, which are clinically proven to work, are brought to your patients’ attention. These products should contain ingredients such as the stain-dissolving agent, Pentasodium Triphosphate and anti-tartar ingredient, Tetrasodium Pyrophosphate.

Pentasodium Triphosphate can remove deep surface stains as part of a daily oral care regime to brighten, lighten and whiten teeth. It also prevents food particles settling on the teeth, effectively keeping teeth whiter for longer. For extra stain removal, Tetrasodium Pyrophosphate coats the surface of the teeth to prevent bacteria forming, leaving teeth feeling and appearing bright all day.

2) “Whitening toothpastes use harsh abrasives to remove stains”
There is a misconception that to remove dental stains caused by smoking and some foods and drinks, patients need to resort to products that contain harsh abrasives. This is not the case. Recommend patients use whitening toothpastes that contain Hydrated Silicon. This low abrasive polishing ingredient, which is frequently combined with the softer calcium carbonate to provide a smooth gel-like quality, works hard to remove plaque and stains and whiten the teeth. It has no distinctive taste or odour and may also be labelled as amorphous silicon dioxide, silicic acid, or silica gel. This mild abrasive is harmless and is even listed by the US Food and Drug Administrative as “Generally Recognised as Safe”.

5) “I suffer from sensitivity so whitening toothpastes are not for me”
Teeth sensitivity is a common dental problem and there are many brands of toothpastes that claim to treat sensitivity. However, recommend patients to use toothpaste that contains Potassium Nitrate. This desensitising agent relieves tooth sensitivity by effectively blocking the transmission of pain sensation through the nerve cells that enable cold and hot sensations to reach the tooth’s nerves. There are toothpastes available that combine Hydrated Silicon for high performance whitening and Potassium Nitrate for rapid sensitivity action.

4) “I tend to suffer from bad breath occasionally so whitening toothpaste wouldn’t be my main concern”
Bad breath is a very common concern and can impact on self-confidence, image and health. Many enjoyable foods and beverages, for example onions, garlic and coffee can cause bad breath affecting ones day to day lifestyle. Activated charcoal has the ability to remove impurities and bacteria and toothpaste containing this ingredient can benefit your patients’ daily confidence and over all oral health. Patients can use the teeth of bad breath, the recommendation of this ingredient, an old age whisper, can help safely eliminate odour causing bacteria whilst maintaining the mouths natural balance. In addition to this, charcoal is known to remove impurities while safely dissolving stains.

Addressing concerns Beverly Hills Formula offers an entire range of products to address all these patient concerns.

Low in abrasion, Perfect White toothpaste contains Hydrated Silicon; stain dissolving agent, Pentasodium Triphosphate; and anti-tartar ingredient, Tetrasodium Pyrophosphate. For extra stain removal, this toothpaste can be left on the teeth for up to one minute before brushing.

And for patients who suffer from sensitivity, but long for that gleaming Hollywood Smile, Perfect White Sensitive is the toothpaste of choice. It contains desensitising agent, Potassium Nitrate.

Boasting an innovative formulation, Perfect White Black contains activated charcoal along with the stain dissolving ingredients in Perfect White to provide a solution for patients looking to combat bad breath whilst also dissolving surface stains.

Ultimately, Beverly Hills Formula’s range of whitening toothpastes offers patients an affordable way to restore the natural whiteness of their teeth by removing stains from the tooth surface, whilst providing that all-important, long-lasting protection.

References

For more information, please call +353 1842 6611; email info@beverlyhillsformula.com; or visit beverlyhillsformula.com

Follow us on Twitter: @BHF_Whitening
The importance of cementation: A veneers case using a new universal cement

By Mitch A. Conditt, DDS

Introduction

Esthetic options in dentistry are the prevailing choice of most patients today. Veneers and bleaching in particular have become buzzwords in popular culture, and TV sitcoms, film and magazine advertising have turned these cosmetic techniques into household names. As a result, dental teams must accommodate the demands of their patients, becoming highly versed in placing metal-free restorations.

Practitioners can find a multitude of educational articles and courses teaching the science and technology of porcelain, zirconia and composites. But while emphasis is frequently placed on the final prosthesis or direct restoration, often overlooked are the increasingly important auxiliary materials that contribute equally to the clinical success of these new materials and restorations: impression and provisional materials, bonding agents and cements. Education is imperative because cementation and bonding are two areas of esthetic dentistry that have evolved through generations of products and techniques. These processes are essential in making esthetic restorations both functional and comfortable.

That's why veneering can be an optimal, conservative alternative to crowning teeth, since preservation of tooth structure is important to dentists and patients alike. The highly esthetic results are due to the fact that ceramics have a translucent finished surface texture similar to that of natural enamel. Dentists, assistants and lab technicians spend vast amounts of time and effort perfecting veneers and avoiding fracture through painstaking preparation, material and shade selection, fit and fabrication. Yet even after such arduous processes, clinical failure and patient dissatisfaction can readily occur with errors in cementation.

Cementing veneers is a delicate process with a historical litany of potential problems – color instability, insertion difficulty, handling and cleanup issues, unsatisfactory radiopacity, low translucency after curing, mismatch between try-in gels and final cements, and debonding, to name a few. Cement selection in certain applications necessitates knowledge of the chemistry and physical properties of the particular cement type, and insertion requires an exacting technique for successful clinical results.

This article outlines a veneer case using NX3 Nexus® Third Generation—a new, universal cement from Kerr. The subject is a long-standing patient-of-record with a current radiological and medical chart. This focus is on the steps and techniques implemented at final cementation of the prostheses.

Clinical Case

A female patient in her mid-fifties presented a chief complaint of being unhappy with her smile. An examination of her hard tissues revealed immediate concerns of multiple fractures, hypocalcification, shortened anterior teeth due to wear and an asymmetrical smile line (Figures 1 and 2).

After proposing a first phase treatment plan to restore all of her compromised upper anterior teeth, the patient consented to restoring only teeth numbers 6-11. The patient ultimately qualified for and accepted veneers as the mode of indirect restorative treatment.

Prior to preparation, the tissue around tooth No. 8 was recontoured. Then, the teeth were prepared for pressed ceramic veneers and provisionalized in the standard manner. Occlusal analysis and adjustments were performed over a period of weeks and the veneers were tried-in. After the requisite steps were completed preceding insertion and the veneers were finalized, the provisionalals were removed and the teeth were cleaned (Figure 5).

Exapal™ was used for gingival retraction and hemostasis in order to gain cervical access and control bleeding in that area (Figure 4).

The teeth were then etched for 15 seconds with Kerr Gel Etchant, which is composed of 37.5% phosphoric acid (Figure 5), and then rinsed and slightly air-dried. (Note: While a total-etch technique was used, NX3 works with both total-etch and self-etch protocols, adding to the distinctiveness of the product.) Per manufacturer directions, OptiBond Solo Plus (kerr) was brushed onto to the tooth surfaces for 15 seconds (Figure 6), air-thinned for 5 seconds, and cured for 10 seconds using the L.E. Demetron B curing light (Kerr) (Figures 7 and 8).

After etching and bonding, the veneers were cemented using NX3 light-cure cement from Kerr. The subject is a long-standing patient-of-record with a current radiological and medical chart. This focus is on the steps and techniques implemented at final cementation of the prostheses.

This article outlines a veneer case using NX3 Nexus® Third Generation—a new, universal cement from Kerr. The subject is a long-standing patient-of-record with a current radiological and medical chart. This focus is on the steps and techniques implemented at final cementation of the prostheses.
Cementation is an important aspect of functional aesthetics. An understanding of chemistry, technology and physical properties are all essential to proper usage and clinical success. Cement selection was the driving factor in choosing the bonding system for this case. NX3 Nexus® Third Generation cement is free of amines—organic compounds containing nitrogen as their key atoms—which were largely blamed for the colour shifts so prevalent with earlier cement formulations. In an earlier use of the product the cement proved to be "thixotropic," the consistency of non-drip paint; the restorations were seated and adjusted before curing with no dripping or running. Color stability, ease-of-use and cleanup, color match and optimum retention are some of the attributes necessary when choosing a cement—NX3 met all of these expectations.

References

Contact details available from the publisher

About the Author
Dr. Mitch Conditt, a 1985 graduate of Baylor College of Dentistry in Dallas, TX, lectures internationally and has published numerous articles reviewing all aspects of restorative and cosmetic dentistry.
Face asymmetries in children and adolescents – Classification and clinical characteristics

By Athanasios E. Athanasiou, D.D.S., M.S.D., Dr. Dent.

Introduction

Perfect bilateral body symmetry is more of a theoretic concept that seldom exists in living organisms. However, pronounced and recognizable face asymmetries do exist and can have serious esthetic, functional and psychological implications. Asymmetry in the craniofacial areas may be the result of discrepancies either in the form and/or size of individual bones as well as malposition of one or more bones in the craniofacial complex. The asymmetry may also be limited to the overlying soft tissues (1). Early detection of face asymmetry may be critical with regard to the diagnosis, prognosis, and therapeutic management. The aim of this article is to briefly present the major categories of face asymmetries in children and adolescents and to provide information on their clinical characteristics.

Etiology

Genetics have been implicated in certain conditions such as multiple neurofibromatoses (Figure 1), hemifacial microsomia, cleft lip and palate. Intrauterine pressure during pregnancy and significant pressure at the birth canal during parturition can have observable effects on the bone of the fetal skull. Environmental factors can cause face asymmetry and may include pathological changes that are not congenital in nature (e.g., osteochondroma of the mandibular condyle), trauma, infection and inflammation within the temporomandibular joint (TMJ), ankylosis of the mandibular condyle to the temporal bone, damage to a nerve, which may indirectly lead to asymmetry from the loss of muscle function and tone, and sucking or chewing habits with influence on tooth position equilibrium (1,2).

Classification

Skeletal Asymmetries

The skeletal asymmetries may involve one bone (e.g., maxilla or mandible) or a number of skeletal and muscular structures on one side of the face.

Hemifacial microsomia

Hemifacial microsomia results from the malformation of the 1st and 2nd branchial arches. It involves mostly unilateral condylar underdevelopment, it may be associated with variable abnormalities of the external and middle ear, has similar manifestations with Goldenhar syndrome, and its etiology is heterogeneous. The extent of TMJ involvement primarily determines severity, prognosis, timing and type of treatment. Face asymmetry in hemifacial microsomia is characterized by chin deviation. Ocular manifestations include lower dental midline deviation, unilateral cross bite, tilting of the occlusal plane, all of them towards the affected side (Figure 2). Apart from ear abnormalities, soft tissue defects may include skin tags, facial clefts, cranial nerve function, soft palate function, bulk of subcutaneous soft tissue, muscles of mastication and facial expression, macrostomia, and skin tags (5).

Hemimandibular hyperplasia

Hemimandibular hyperplasia is an uncommon maxillofacial deformity characterized by increased ramus height, rotated facial appearance, and kinking at the mandibular symphysis. Usually it is associated with prominence of the lower border of the mandible, maxillary and mandibular alveolar bone overgrowth, compensatory canting of occlusal plane, and serious functional malocclusion (4) (Figure 5). Hemimandibular hyperplasia presents diffuse enlargement of the condyle, the condylar neck, the ramus, and the body of the mandible, it usually begins before puberty, is clearly due to hyperactivity in the condyle, whose cartilage actively proliferates.

Condylar fracture

Condylar fractures in growing individuals are usually the results of accidents and sports (Figure 4). In children they are often overlooked by parents and physicians since short time after the injury symptoms of pain usually disappear. The majority of condylar fractures in children, if properly diagnosed and man-
Aging by short-term intermaxillary fixation and subsequent physiotherapy, do not lead to morphological and functional problems. However, no diagnosis of condyle fractures may lead to face asymmetries, severe malocclusion and TMJ ankylosis (5).

**TMJ ankylosis**

It is a chronic hypomobility and, if happens in growing subjects, it becomes a growth disorder (Figure 5). It results from intracapsular adhesions or ossification between the disc and temporal articular surface that attach the disc-condyle complex to the articular eminence. Its classification relates to the degree of limitation (partial or complete), location of the union (intracapsular vs. extracapsular), and type of tissues involved (fibrous, osseous, fibro-osseous). TMJ ankylosis occurs relatively infrequently. Principle causes include trauma, previous joint surgery, systemic or local infections, tumors, compressive function pattern and systemic diseases (6). Regarding history, patients report limited mouth opening without any pain, the condition has been present for a long time, and, if not associated with severe dentofacial deformity, patients do not feel that it poses a significant problem.

**Muscular and Soft Tissue Asymmetries**

Facial disproportions could be the result of muscular and soft tissue asymmetry (e.g., hemifacial atrophy or cerebral palsy), muscle size disproportion in volume and/or toxicity (e.g., mas-seter hypertrophy, dermatomyositis (Figure 6), and neoplasms (Figure 7)). Abnormal muscle function often leads to skeletal deviations (2).

**Functional Asymmetries**

Functional asymmetries can result from lateral or anteroposterior deflections of the mandible due to occlusal interferences, which prevent proper intercuspidation in centric relation (e.g., functional crossbites) (1). Functional crossbites in children, if left without correction, subsequently may cause mandibular asymmetry.

**Conclusions**

Face asymmetries in children and adolescents should be detected and diagnosed as early as possible. Early detection may be critical with regard to the prognosis and therapeutic management of this challenging dentofacial deformity.

**References**


**About the Author**

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**Hamdan Bin Mohammad College of Dental Medicine**

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**Speakers:**

**Professor Crawford Bain**
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**Professor Samira Al-Salahi**
Director of Endodontic Programme
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**Date:** March 02, 2015
**Time:** 07:45 pm – 08:30 pm

**Lecture 1**
**Endo-Perio Lesions Revisited**

**Professor Wael Ait**
Head of Restorative Dentistry
HBMCDM

**Date:** April 06, 2015
**Time:** 07:45 pm – 08:30 pm

**Lecture 2**
**Extremely Worn Dentition: New Frontiers and treatment Strategies**

**Dr. Samy Darwish**
Assistant Professor
In Oral Surgery Department
HBMCDM

**Date:** March 02, 2015
**Time:** 08:45 pm – 09:30 pm

**Lecture 3**
**Consent in Dentistry**

**Dr. Adil Mageet**
Associate Professor
Orthodontic Department
HBMCDM

**Date:** April 06, 2015
**Time:** 08:45 pm – 09:30 pm

**Lecture 2**
**Non-surgical treatment of CL III malocclusion**

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Diplomate American Board of Prosthodontics

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Clear fixed appliances chosen over aligner treatment for arch development

By Dr. Stuart Frost, USA

Pretreatment Diagnosis

Class I (end to end molar on right), female patient, 58, presented for clear aligner treatment. She had had orthodontic treatment years before. Given that her chief concerns were the crowding in her lower arch and widening her smile, I was able to convince her that passive self-ligation would offer her the results she wanted and could satisfy her need for esthetics since Damon Clear was then available in prototype. She had no jaw popping or clicking.

Facial/Soft Tissue/Macroesthetics: Mildly convex profile and nasolabial angle. Slight lip strain at rest with lower midline shifted to the right.

Smile/Miniesthetics: Excessive upper gingival display, narrow arches with 5 to 4 mm of crowding in the lower arch and 1 to 2 mm of crowding in the upper arch. Consonant smile arc.

Teeth/Macroesthetics: Esthetically shaped teeth and excellent hygiene. Inconsistent gingival macroesthetics since Damon Clear was then available in prototype. She had had orthodontic treatment years before. She had had orthodontic treatment years before.

Treatment Objectives and Plan

Treatment allows us to achieve outstanding results. While clear aligner treatment can satisfy certain patient objectives. Widening the transverse arch width, especially U2-2, also diminished the excess gingival display.

What I Would Do Differently Today

The patient had a lateral tongue thrust at the UR5. Were I to treat the case today, I would place lingual tongue reminders on the UR5 that would likely have resulted in a more satisfactory Class I right cuspid relationship.

References

1. All Copper Ni-Ti wire used is Damon Optimal Force Copper Ni-Ti.
Dubai Healthcare City’s Medical University Announces New Identity of its First College - Hamdan Bin Mohammed College of Dental Medicine

By Dental Tribune MEA

Monday, February 16, 2015: Ahead of the 10th edition of the UAE International Dental Conference and Arab Dental Exhibition – AEDC, Dubai Healthcare City (DHCC), the world’s largest healthcare free zone, today announced the first college of the Hamdan Bin Mohammed College of Dental Medicine (HBMDM), formerly the Dubai College of Dental Medicine.

Dubai, February 16, 2015: Ahead of the 10th edition of the UAE International Dental Conference and Arab Dental Exhibition – AEDC, Dubai Healthcare City (DHCC), the world’s largest healthcare free zone, today announced the new identity of the Hamdan Bin Mohammed College of Dental Medicine (HBMDM), formerly the Dubai College of Dental Medicine.

The Hamdan Bin Mohammed College of Dental Medicine is the first college established under Dubai Healthcare City’s first medical university, the Hamdan Bin Rashid University of Medicine and Health Sciences (MBR-UMHS). It promotes an integrated learning environment through its Dubai Dental Clinic and through DHCC’s medical education entities under the Mohammed Bin Rashid Academic Medical Center (MBR-AMC).

“Education is a key pillar supporting our nation’s sustainable growth and knowledge-based economy,” said HE Dr Raja Al Gurg, Vice-Chairperson of Dubai Healthcare City Authority. “Medical education entities will help improve clinical performance that will, ultimately, drive excellence within the healthcare system.”

The College offers six postgraduate programmes, accredited by the Ministry of Higher Education and Scientific Research examined in collaboration with the UK-based Royal College of Surgeons of Edinburgh (RCSEd). As of January 2015, 150 residents were enrolled.

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*compared to Damon Clear, data on file. Standard bracket, upper 28 brackets.

By Dental Tribune MEA

LEIDEN, Netherlands: Dental caries is one of the most common chronic childhood diseases worldwide and can affect a child’s quality of life significantly. Several studies have identified a correlation between caries and lifestyle factors, such as physical activity and meal frequency. A team of researchers has now found that, especially for younger age groups, regularity and a structured lifestyle are very important for preventing caries.

The researchers at the Netherlands Organisation for Applied Scientific Research examined the impact of such factors on caries experience at different ages. They based their study on the data collected in a previous study on oral health in children and adolescents in the Netherlands that aimed to describe the oral health status and the preventive dental behaviours of 9-, 15- and 21-year-olds.

The scientists used the existing data, collected through questionnaires and clinical oral examinations, to study the probability of caries and the degree of caries experience in relation to several lifestyle factors. The lifestyle factors included were the frequency of toothbrushing per day, the frequency of having breakfast per week, and the frequency of food and drink consumption per day.

The 21-year-olds examined in the study did not show significant differences in caries experience in relation to the lifestyle factors studied. For the 9- and 15-year-olds, however, the lifestyle factors had a significant effect on their dental caries experience.

For the two younger age groups, not having breakfast and not brushing their teeth twice a day were associated with a significantly higher caries experience. In addition, consuming food or drinks more than seven times a day resulted in an increased caries experience for the 9-year-olds.

The findings of the study demonstrate that components that promote structure and regularity in a child’s life, such as having breakfast and the frequency of food and drink consumption per day, are essential to preventing caries.

According to the researchers, it would be helpful to include these lifestyle factors in programmes to prevent dental caries in children and to communicate preventive messages about the consumption of food and drinks between different health and oral health professionals.

The study, titled “Impact of lifestyle factors on caries experience in three different age groups: 9, 15, and 21-year-olds”, was published in the February issue of the Community Dentistry and Oral Epidemiology journal.
Drill through the tooth technique for molar implant placement

By Dr. André C Hattingh BChD, MChD cum laude, Specialist Periodontist & Dr. Costa Nicolopoulos BDS cum laude, FFD (SA), Oral & Maxillofacial Surgeon

The immediate placement of a "conventional" (6-8 millimetre diameter) dental implant into a molar extraction socket poses a number of difficulties. Most significantly is the size and shape of the multi-rooted molar socket. It is not suited for optimal placement of a typical dental implant and often results in compromised implant positioning, poor primary stability or the inability to place an implant at all. This may result in the need for a waiting period of 3 to 6 months, to allow for healing of the socket and bone formation prior to attempting implant placement.

This waiting period often ends in reduced bone volume (height and width), which is inadequate for implant placement and the resulting need for bone augmentation procedures, especially in the posterior maxilla. This necessitates longer treatment times with increased cost and complexity. An alternative approach has been to place a 5.6 millimetre diameter implant into one socket of a multi-rooted extraction site, typically the palatal socket of a maxillary molar. Problems associated with the latter approach include adverse biomechanical forces resulting from the implant being off-centre and off-axis to the application of load. Poor emergence profile and difficult plaque control also result from the unavoidable buccal overhang of the restoration.

The ability to place an implant immediately into a fresh molar extraction site embodies a major advantage in molar tooth replacement. This modality is however critically dependent on the preservation of the peri-implant bone walls of the socket at extraction. In a case of a multi-rooted molar tooth, it is recommended not to attempt a conventional extraction, but to plan for the individual removal of roots in order to avoid potential fracture of the buccal plate. If the crown of the molar is cut off horizontally (Fig.1), preparation of the osteotomy site can be initiated through the pulpal floor (Fig.2) and into the interradicular bone septum (Fig.5).

It is important to consider the peridental biotype of the patient when applying this protocol. Medium to thick periodontal biotypes are the most suitable cases. Thin biotypes are contra-indicated for this treatment approach and it is recommended that "traditional delayed protocols" are followed for thin biotypes.

Preparation of a pilot hole through the pulpal floor (Fig.2) of a decoronised molar (Fig.1) should specifically be directed slightly toward the lingual aspect (Fig.5) in the case of a mandibular molar and slightly to the mesial aspect (Fig.6) in the case of a maxillary molar. Maxillary molars often have more space available on their mesial aspects (between the first and second premolar) than on their distal aspects (between the first and second molars – Fig.6).

It is of the utmost importance that these initial preparation guidelines are followed in order to ensure that the final osteotomy preparation is away from the buccal wall (in the case of a maxillary molar where the bucco-lingual dimensions are critical) and away from the mesio-buccal root of the maxillary second molar (in the case of an upper first molar replacement). The aim is to initiate preparation in the following positions:

- Mandibular first molar (Fig.5)
- Maxillary first molar (Fig.6)

The roots can then be sectioned and carefully removed taking care NOT to remove any bone in the process (Fig.7a). It is essential to then inspect the socket walls and to ensure that all 4 walls are present and intact. If any of the required 4 walls are absent or significantly damaged, immediate implant placement becomes contra-indicated and a delayed protocol is then advised. Once the roots are removed, further preparation of the socket is carried out to create a suitable tapered shape (Fig.12) that could receive the implant. Incremental preparation is used (Fig.7b) before finalizing the site.

Finalization of the placement site is achieved with a dedicated Max drill (Fig.8) specially developed for hard bone. These drills match all the available implant lengths and diameters in the range of the Max implant. In softer bone the pre-placement preparation can be finalized with a dedicated Max tap (Fig.9). Lateral compression of soft bone is enhanced by the use of this instrument, as is the accuracy of osteotomy site finalization in terms of position and angle. These taps again, match all the available implant lengths and diameters in the range of the Max implant. They can be hand driven using a surgical wrench as demonstrated in Fig.10 & 11. The taps are specifically designed with a strengthened portion on the driving shaft, near the neck of the instrument. This contains a hexed collar, which slots into a sleeve, allowing connection to a surgical handpiece. Potential instrument fracture and damage to surgical handpieces, are significantly reduced by this innovation.

A third finalization instrument can be used in situations where the interradicular bone anatomy

Fig. 1. Mandibular molar decoronised at cervical level
Fig. 2. Pilot hole preparation through pulpal floor
Fig. 3. Drill through pulpal floor into interradicular bone septum
Fig. 4. More bone available on the mesial than on the distal of an upper first molar
Fig. 5. Preparation started slightly toward the lingual in the case of a maxillary molar
Fig. 6. Preparation started slightly toward the mesial in the case of an upper molar
Fig. 7a. Careful removal of roots without any bone removal
Fig. 7b. Incremental preparation with conventional drills
Fig. 8. Dedicated Max drill
Fig. 9. Dedicated Max taps
Fig. 10. Dedicated Max tap driven with surgical wrench
Fig. 11. Dedicated Max tap driven with surgical wrench
Fig. 12. Preparation of centrally located interradicular bone septum
Fig. 13. Osteotome in place to assess preparation before implant placement
Fig. 14. Osteotome in place
Fig. 15. Osteotome design
Fig. 16. Osteotome in molar socket used to finalization of preparation
Fig. 17. Max implant for molar extraction sockets
Fig. 18. The 2x2 position rule
Fig. 19. Laser markings on fixture mount at platform level and at 3mm
Fig. 20. Healing abutment connection and soft tissue adaptation with sutures
Fig. 21. Healing abutment connection and radiographic evaluation
Fig. 22. Restoration immediately after placement
Fig. 23. Follow up at 1 year
is thin or ill defined. The Max osteotome (Fig.15) also match all the available implant lengths and diameters in the range of the Max implant. It doubles up as a profile gauge which can be used in the osteotomy site to assess the preparation depth and position prior to committing to placement (Fig.15). It is useful to confirm the preparation position radiographically, once preparation finalization has been reached (Fig.14). This instrument has a central stalk with a concave profile. The concave dimples on the base of the instrument are used to steer the osteotome in different directions, while the central dimple on the stalk serves as the main driving point. A rod shaped “chisel” is placed into these concave hollows, which in turn is driven by a surgical mallet. The central stalk is used to retrieve the instrument after use (Fig.16).

The Max range of implants are designed specifically for immediate placement in to molar extraction sockets. They are available in 7, 9 and 11mm lengths and in 7, 8 and 9mm diameter. The tapered design makes them ideal for immediate placement in fresh molar extraction sites (Fig.17). They have a moderately rough surface which is created by sandblasting and chemical conditioning with solvents of a grade 4 c.p. titanium. The restorative connection is available in an external hex, tri-tex or internal octagon design. The wide diameter of these implants enables platform switching of at least 0.25mm in the horizontal plane and a further 0.5mm if the 45 degree bevel at the implant shoulder is included. Accurate and correct placement position and depth is vitally important for the long term success of this treatment protocol. The golden rule is termed the 2:1:2 position (Fig.18). The implant should always be 2mm below the lowest point of the buccal wall crest and 2mm in (palatally or lingually) from this point. The implant should NEVER touch the buccal bone plate when it reaches its final placement position. Primary stability in the case of a tapered wide diameter implant can be extremely positive and can reach values that are much higher than those we are accustomed to, when using “conventional” diameter dental implants.

The fixture mount on the dental implant has stripped laser markings at the implant platform height and at 5mm (Fig.19). These can be used to assist with periodontal and implant related topics in Australia, England, Belgium, Botswana, Greece, Holland, Iceland, Ireland, Scotland, South Africa and the USA.

Dr. Costa qualified cum laude as a dentist in 1984 receiving numerous awards including the Gold Medal of the Dental Association of South Africa for the most outstanding graduate. In 1990 he completed his 4 year postgraduate Maxillo-Facial & Oral Surgery training. Since 1991 he is in full time specialist Oral & Maxillofacial Surgery private practice & has placed over 30,000 dental implants. In 2012 he established the SameDay Dental Implants Clinic in Dubai where he is also the co-director of the Bruenmark Osseointegration Center.

About the Authors

Andrew Hattingh is a specialist periodontist in full time private practice in Sevenoaks, Kent, United Kingdom. He qualified as a dentist in 1991 and worked in general dental practice for 4 years. In 1996 he started a four-year full time postgraduate Masters degree in Periodontology and Oral Medicine which he received with distinction in 2000. He obtained both of his qualifications from the University of Pretoria in South Africa. He is chairman of the Tansmere Wells Postgraduate Periodontal Group and has been placing dental implants for 16 years. He has presented lectures on periodontal and implant related topics in Australia, England, Belgium, Botswana, Greece, Holland, Iceland, Ireland, Scotland, South Africa and the USA.
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Troughing: Detection of three canals in the mesial root of an upper molar

By Dr. Carlos Vidal Tudela

Summary

The complex anatomy of the root canal system is a determining factor in the success of Endodontic therapy. The elimination and permeabilization, even for the most experienced dentists, is a very complex task even for the most experienced dentists. The combination of the use of the microscope together with the arrival of the ultrasound to the area of the root canal means that manoeuvres such as “trenching” make it easier and more effective to locate the entrance to the conduct. In this article we present key words and concepts such as access, access orifice, canal, the complex anatomy of the root canal system. We refer to the percentage of a more complex root system such as the mesiobuccal root.

Key words

- Trenching, Surgical microscope, Ultrasonic, Three canal Mesiobuccal root.

Introduction

The sealing of endodontic pathology is conditioned by the capacity of controlling the infection within the complex anatomy of the root canal (1). The upper first molar is a tooth that presents a complex anatomy in its mesiobuccal root. Pineda (2), Weine (3), Vertucci (4), and Brown Herbstman (5) describe the anatomical complexities a practitioner should confront.

On the other hand, the identification of three canals in the mesiobuccal root of an upper molar is a fact relatively rare as shown in the specialized literature (5). Traditionally, the DG 16 exploration probe has been the clinical method used to find the existence of a third canal in the mesiobuccal root. The use of the Surgical Microscope and the ultrasound for the localization and permeabilization of the mesiobuccal root is a fact relatively rare as it can be observed in the specialized literature (6).

With the arrival of the Surgical Microscope (7) and the use of ultrasound in endodontic therapy, the “trenching” manoeuvre is being carried out, which means to create a depression or open a path at the floor of the pulp chamber for better access to the orifices of the pulp canals. The aim of this article is to describe the “Trenching manoeuvre” and to illustrate a clinical case in which three conduct in the mesiobuccal root of a upper first molar are present.

Classification of weine for the conduct of the mesiobuccal root

Weine proposes four types to describe the configuration of the main conducts in the mesiobuccal root (3), of the upper molars (Fig. 1):

- Type I: one conduct from the entrance orifice to the apex.
- Type II: two orifices that converge into one at the apical foramen.
- Type III: three orifices of entrance at the pulp chamber and two separated conducts from origin to the apex.
- Type IV: one orifice of entrance at the pulp chamber to three separate conduct with independent apical orifices.

The configurations of Type II and III represent almost 95% of the cases (Fig. 1).

Classification of vertucci for the mesiobuccal root

Type I: one conduct, one entrance orifice to the apex.
Type II: two conducts that fuse at the apical third.
Type III: three conducts that divide in two and re-join into one.
Type IV: two separate conduct till the apex.
Type V: one conduct dividing near the apex.
Type VI: two conducts that fuse along the root and divide once again at the apex.
Type VII: one conduct that divides in two as in the upper molar.
Type VIII: three separate canals exits.

Description of the trenching manoeuvre

Trenching allows the view of the conducts Orifices of the pulp chamber. Only the main conducts are located. The technique of access to the pulp chamber is a key procedure for good practice in Endodontic treatment.

The opening shall be direct at the possible site of entrance of the pulp chamber with refined walls. Over-expansions of the root of the pulp chamber shall be avoided and perfect visualisation should be permitted at all entrances of the conduct, which should be situated at the angle lines between the walls of the pulp chambers and the floor.

The use of the surgical microscope allows a better vision of the dentin we wish to remove in the mesiobuccal root.

At first, by using the probe DG11 we locate the three orifices of entry of mesiobuccal, distobuccal, and palatal conducts, probably in its traditional triangular disposition.

At this point, we should refine the access to the pulp chamber by using ultrasound, in this case directly connected to the equipment house. We use a Kurz scaler (Fig. 5), with flat head and diamond tip (Komet), which will avoid stops on the pulp chamber floor. Thus, the ultrasound will allow us to eliminate small calcifications and delimit the angle lines connecting the three main conducts. Finally the use of the ultrasound permits a direct access for the observation with the Surgical Microscope and the instrumentation of the conduct exempt of interferences (Fig. 4, 5 and 6).

Among the different options to permeabilize the mesiobuccal conducts 2 and 5, if there were any, we propose the Pro Taper file F1 or Reciproc R25 in order to open these extra canals without permeabilization. No matter how risky this manoeuvre may seem, it is efficient as long as we keep its use to the coronal millimetres and refrain from the temptation of continuing to open the apical zone of the mesiobuccal conduct, to avoid the screw and blockage effect, which would lead to fracture.

Once opened, the mesiobuccal conducts 2 and 3 are permeabilised with the apical files size 10 and 15, and we can determine our conductometry with the use of apex locators and confirm the instrumentation till the obturation (Figs. 8 and 9).

Discussion

With the NITI rotary files, the new optical illumination, magnifying methods and with the contribution of the ultrasound, the “trenching” manoeuvres are necessary for the opening access of the teeth, both in BC or retreat, where a high percentage of the refractory chronic periodontitis towards an endodontic therapy is due to the non-localisation of more than one conduct in a root (8).

According to Wolcott and cols, while endodontic literature shows numerous articles related to the prevalence of two conducts in the mesiobuccal root of an upper molar, there are not so many articles describing the presence of a third conduct in the mesiobuccal root of an upper molar.

Although the literature already indicates the existence of a third canal in the mesiobuccal root is not common, there are authors that refer to the percentage of a molar with a type 8 configuration in root as 6% (9). The lack of knowledge thereof can lead to treatment failure (10). It is important to fully understand the anatomy of the upper first molar, and with the help of a microscope and ultrasound will be able to master the mesiobuccal root of the upper molars.

In our day to day practice it is normal to find more than two conducts, as it can be observed in the following clinical examples. We need to understand that the mesiobuccal root is oval-shape root and not round root. In most cases if there is more than one canal we will find itms us we will need to prepare.
Innovations in Maxillofacial Surgery: Guided Maxillofacial Surgery

By Dr. B. Philippe (MD) Maxillofacial Surgeon

The precise realisation of osteotomies and exact positioning of skeletal parts released by osteotomy maneuvers can be concerns for maxillofacial surgeons. Guided maxillofacial surgery represents one of the latest innovations in maxillofacial surgery and consists of simulating a computer osteotomy to ensure accurate three-dimensional positioning of intraoperative bone cutting and precise drill guides created through the use of miniplates that have been manufactured before surgery with commercially pure porous titanium (CPTi) under direct metal laser sintering (DMLS).

The size and shape of these prefabricated miniplates will match exactly to the anatomy of the skeletal parts released by osteotomy maneuvers and the spaces created by the respective movement of skeletal fragments. The surgeon can dispense with traditional osteosynthesis.

The joining of these miniplates also eliminates any intraoperative bending that can occur in miniplates and promise precise positioning of the skeletal parts. After creating the computer simulation of the planned osteotomy by the surgeon, the DICOM data of the simulation is sent to the biomedical engineer who then draws the prototype of the osteotomy guide based on the recommendations of the surgeon. The stability of the osteotomy guide on the maxilla is determined by its close contact with the underlining bone and this can be augmented by the placement of mini-screws. The design of the osteotomy guide must ascertain the precise execution of the LeFort I osteotomy. Once the design of the osteotomy guide is validated by the surgeon, it is produced using a rapid prototyping machine, stéréolithographie (Fig.1).

The design of the custom-made titanium miniplate system completed by the biomedical engineer takes into consideration multiple factors, in particular, the size and form of the system. The miniplate system must lie on the maxilla in a completely passive fashion, without transmitting any tension or trauma to the underling bone. These custom-made miniplates are created as a single unit, initially joined together to allow for their use as a positioning guide. The use of this guide permits maximal congruent contact between the bony segments and the miniplates themselves and thus enables the precise positioning of the skeletal segments freed by the osteotomy. The miniplates are joined together either in 4 by 4 configuration (LeFort 1 osteotomy) or in 2 by 2 configuration (sagittal split, genioplasty). The positioning and depth of the miniplates are known with accuracy, and this can be augmented by additional screws to ensure the best position of placement during virtual surgery planning.

During virtual surgery planning, the length of the screws and their best position of placement can be ascertained in function to the thickness and density of the underlying bone. It decreases the length of time needed for the surgical procedure.

- It decreases any associated trauma from the underlying skull and the desired skeletal displacement of the bony segments.
- It makes the operation much easier for the surgeon and decreases the time spent in the operating room.

Guided maxillofacial surgery is mainly discussed in orthognathic surgery and implant surgery (LeFort I indicated for maxillary acquired atrophy) but other applications can also benefit from guided surgery:

- In patients who have unilaterial deformities, the final result of the facial bone reduction and fixation can be based on the contralateral normal skeleton. In this situation, the miniplate system can be designed based upon a contralateral face by symmetrising digitally from the midline.
- All cranio-maxillofacial osteotomies or maxillofacial reconstructions may benefit from this new type of custom-fit miniplate osteosynthesis.

References

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- Oral surgery in the dental clinic: Review and results
- Implant crown restoration
Always a perfect healing with P.R.F. (platelet-rich fibrin)

By Dr. Dominique Caron

After any wisdom tooth extraction here is a first quick introduction to a smart technique.

You are happy, your bony complication 58, looking like a plug for hollow brick, is out.

You performed the removal nicely but you are now preparing the second step, which is not fully in your hands: the healing.

As a practitioner, however you are facing:

- Guns: Out and set apart
- Bone: Naked, scratched and wounded
- Empty socket welcoming food collection
- Dental nerve often naked at the bottom of the socket.

Of course, you hope for a quick healing with no infection, no swelling nor pain.

There is a very efficient way of helping nature, to give the times and the means to recover:

You can bring massively in the socket the natural angiogenic, cicatrization building materials that the body naturally brings too slowly.

You need fibrin, platelets, leukocytes, cytokines and growth factors.

All of these components are available in patient's blood, all you have to do is to extract it and concentrate it in the socket.

The process:

Just before starting the surgery, you set the stitches as usual but before doing the knots, fill the socket with P.R.F.

- ACCURATE: You are sure to fill the socket (that allows much less food collection)
- The dental nerve is immediately protected
- Hemostasis: You get a quick clot filling the socket (that allows much less food collection)
- EFFICIENT: Enhances the body’s natural healing.

To conclude, this smart French technique can render your patient's life and yours much happier!

Stay tuned for further articles with all other applications.

References
2. Oral Surgery, Oral Medicine, Oral Pathology, Oral Radiology and Endodontology N 101 March 2006 Dr. Dominique Caron, Better healing and lower discomfort for the patient with P.R.F.
3. Study on 57 patients between 2010-2014.

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“The Middle Eastern dental market is one of the fastest growing markets worldwide”

By Dental Tribune MEA

DEUBAI, UAE: Ritter Concept is known for offering 127 years of Dental Experience. The German owned and operated company has all their products ‘Made in Germany’ at the modern production facility located in Zwönitz (Saxony, East Germany). The company is known for a Leading Edge Design and High Level of Function. We interview the CEO of Ritter, Mr. Werner Schmitz to find out his thoughts on Dentistry.

Dental Tribune MEA: Mr. Werner Schmitz, it is a pleasure to interview you. Could you tell us how you became involved with Ritter and the changes that have taken place since you became CEO?

Mr. Werner Schmitz: When I took over Ritter in 2004, the company faced a relatively difficult situation. In the following years the business has been continuously built again. We re-launched our portfolio and continuously built again. We amended it with modern and highly innovative dental units, autoclaves, compressors and x-ray devices in order to offer an overall-concept to the dentists. Step by step we re-gained the confidence and trust of our customers. Today the Ritter product range contains more than 20 product divisions, which are available worldwide. Users appreciate Ritter products for their high product quality, innovative technologies, reliability and easy maintenance aspects – Made in Germany.

How does Ritter stand out amongst the highly competitive dental industry?

Ritter is able to benefit from a 127 year old history and the corresponding experience. Though we foster the old values of a still owner-managed company, combined with modern processes and products, in our daily work as well as in the relationship to our customers. Therefore the ‘let’s say Unique Selling Point – owner-managed’ is relevant for the company’s success. Most of the German companies are characterized by rational and economic intentions, which are dictated by the investors. Ritter’s understanding of a company’s philosophy is completely different and based on a mutual understanding and a fair and reasonable partnership. Ultimately I haven’t made all these efforts within the last 11 year in order to sell the company at a later point. I will rather pass it over to my family and children. The stability of values is not only reflected in our image, but also in the product range. Ritter does not use standard plastic components for the products but parts made from fiberglass, metal, aluminium, etc. The difference is obvious: Longevity, solidity and low needs for service or repairs. Paired with our flexibility and lean structures, Ritter is able to offer premium products at a very interesting price-ratio-performance to the users.

As of 1st of June 2014 Ritter signed a deal with Henry Schein for an exclusive cooperation for the Middle East. How has and will this help you to develop your presence here in the MEA region?

Ritter is delighted to set up the latest sales and service approach with such a strong and internationally experienced partner like Henry Schein. We believe, that the mix of local background and knowledge of two global companies will be the gateway to success. Henry Schein Middle East LLC is based in Dubai directly. All customer requests can be handled locally, in a quick and flexible way. The technical engineers are specialised in the installation and service of dental equipment. Moreover Henry Schein provides a strong network of dedicated Henry Schein distributors in each country. The experienced Ritter Export Managers support all activities continuously. The customers receive a full-service spectrum of care. Also the upcoming tradeshows in Dubai represents a good opportunity to show our common strengths. We strongly believe that this partnership will create a wide range of synergies and services from which our clients will benefit.

What is your impression of the Middle Eastern Dental Market and level of Dentistry?

In my opinion the Middle Eastern Dental Market is one of the fastest growing markets worldwide. Users emphasise on high-level products with outstanding quality aspects. Also the product design plays an important role. Practises in the Middle East are equipped in a very modern and innovative way and the users attach importance to provide first class dental treatments to their patients. To all these aspects, Ritter has the appropriate answer with a sophisticated range of products and services.

How do you educate your current clients and what are your plans in enlarging your client portfolios in the region?

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For 2015 we worked out a joined marketing plan with our exclu- sive partner Henry Schein. This contains a wide range of activities, press releases and reports in dental newspapers, magazines and online media. On the ground we will provide information by the means of local showrooms and VIP clinics. These institutions will offer access for interested dentists to Ritter dental units and products. Also the user in the VIP clinics will share their experiences in daily work with Ritter products. Also trainings for dentists and technicians will be available in several local areas. For us it is crucial to provide direct personal consultancy and comprehensive local services to our customers.

In this IDS year, will there be major new developments for Ritter which we will see in the MEA region?

Of course we will present novelties in the fields of dental units, x-ray devices and compressor/suction. We are more than proud to show our new and modern dental unit ARIA SR with outstanding design-opportunities and convincing qualitative aspects for every user. The ARIA SR will bring a new understanding of modern dental units into the practices worldwide. More detailed information about the new products will be presented during the tradeshow in Dubai in February and later this year during the IDS in Cologne in March. This means, the Middle Eastern countries will benefit from being one step ahead regarding the product launch.

What do you expect from Dental Tribune Middle East & Africa?

For sure the Dental Tribune MEA offers a great platform of communication to us. Or expectation is to spread the message of the Ritter products, technologies, support and training services within the users in the Middle Eastern countries and to cover all informative aspects. In this regard we trust in the support of Dental Tribune MEA, which is always present on the pulse of events and happenings.

26th SDS Int’l Dental Conference was attended by over 3000 participants

13-15 January 2015, Riyadh International Convention and Exhibition Center, Riyadh

By Saudi Dental Society

The Saudi Dental Society recently held its most important and the largest scientific gathering in the Kingdom. The 26th Saudi Dental Society International Dental Conference with this year’s theme, “Innovative Digital Solutions in Dentistry” was held last 13-15 January 2015 (22-24 Rabi’1 1436H) at the Riyadh International Convention and Exhibition Center in Riyadh, Saudi Arabia. The conference was attended by over 5000 participants (dental specialist, dental technicians and assistants) from the various government and private sectors, universities, hospital and institutions.

The celebration commenced with an opening ceremony attended by highly distinguished guests led by the Prince of Riyadh and other dignitaries and guests.

The six scientific sessions featured lecture presentations given by 18 international keynote speakers from USA, UK, Germany, Switzerland, Sweden, Brazil, France, Spain, Netherlands, Lebanon, Jordan and Canada including 8 local speakers on various dental specialties. In addition to the 11 Continuing Education Courses and Workshops conducted during the three-day conference, two pre-conference workshops were given on 10-12 January 2015.

The highlight of the conference was the Research Award’s Competition for the Young and Graduated Dentists and Poster Presentation Competition. There were four presenters for the Young Dentists, six presenters for the Graduate Dentists and 127 posters offered the opportunity for other participants to present their research in poster sessions.

The scientific programs was also complemented by 55 well-organized exhibitions of numerous leading medical and dental companies featuring the latest equipment, materials and devices in the medical and dental world.
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In Fulfillment of the Educational Requirement for the Examination for Associate Fellow Membership for the American Academy

The Faculty are as follows:

**Dr. Shankar Iyer, USA**  
Director, AAID MaxiCourse®-UAE  
Diplomate, American Board of Oral Implantology  
Clinical Assistant Professor, New York University, College of Dentistry & LIPAIUJU

**Dr. Ninette Banday, UAE**  
Manager of Dental Services, AHS-SEHA  
Co-Director AAID MaxiCourse®- Abu Dhabi, UAE

**Dr. Amit Vora, USA**  
Diplomate of the American Board of Periodontology  
Professor (parttime), JFK Hospital and the Veteran Affairs (V.A.) Hospital

**Dr. Jaime Lozada, USA**  
Director of the Graduate Program in Implant Dentistry  
Fellow, American Academy of Implant Dentistry

**Dr. William Locante, USA**  
Diplomate of ABOID  
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**Dr. Natalie Wong, Canada**  
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Fellow, American Academy of Implant Dentistry

**Dr. Kumar Vadivel, USA**  
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**2011 Program Accredited by Health Authority Abu Dhabi (HAAD) for 210 CME Hours**  
**2012 Program Accredited by Health Authority Abu Dhabi (HAAD) for 224 CME Hours**  
**2013 Program Accredited by Health Authority Abu Dhabi (HAAD) for 234 CME Hours**  
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**Venue & Dates**

- **SEHA- AHS Healthcare Centers**  
  Abu Dhabi University
- **Module 1**  
  25th - 30th January 2015
- **Module 2**  
  30th March - 4th April, 2015
- **Module 3**  
  22nd - 27th May, 2015
- **Module 4**  
  2nd - 7th September, 2015
- **Module 5**  
  3rd - 8th November, 2015

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**Registration**

Pre-Registration is Mandatory as it is a limited Participation Program.  
For further information and registration details visit website: [www.aaid-asia.org](http://www.aaid-asia.org) or e-mail  
**Dr. Ninette Banday**, Dental Services Manager, Restorative Dentist & Implantologist, AHS-SEHA, Abu Dhabi  
Coordinator AAID-MaxiCourse UAE at [drnbanday@yahoo.com](mailto:drnbanday@yahoo.com).
Henry Schein Middle East welcomes VIP’s in world’s tallest hotel – Marriott Marquise Hotel Dubai

By Dental Tribune MEA

DUBAI, UAE: Tuesday 17th February 2015, Henry Schein Middle East gathered over 120 VIP custom- ers and dealers from the Middle East region for a remarkable event in the world's tallest hotel, Marriott Marquise Dubai.

Henry Schein is the largest global dental distributor of health care products and services to general practitioners, specialists and laboratories throughout the world. The primary objective of the company is to partner with its customers in order to improve the practice efficiency and productivity that enables the customers to focus on delivering quality care to their patients.

The network of exclusive Henry Schein Middle East Distributors offer dentists a complete portfolio from high quality and value priced consumable and equipment product manufacturers that customers can rely on to fulfill their practice needs.

In the middle of the Emirates Ballroom at the skyscraping Marriot Marquise stood a complete built clinic including 12 different manufacturers that can supply all the requirements for the daily use of a dental clinic with different dental specialties. The Henry Schein Exclusive Partners including Henry Schein Brand Products, ACE Surgical Supply, B.A. International, BUSA Dental Instruments, Camlog, Ortho Organizers and Henry Schein Connect Dental. The Henry Schein Exclusive Suppliers Partners included Air Techniques, CAO Group, Osstell, Planmeca and Ritter Dental.

Dr. Ghassan Nasser (Sales & Marketing Director Middle East and North Africa) together with Mr. George Aalto (General Manager, International Dealer Sales) opened the evening with two presentations on the overview of Henry Schein as a leading dental supplier company worldwide and the future plans for the Middle East and North Africa markets. Managers from the 12 dental manufacturers of Henry Schein companies had the chance to meet the VIP customers and dealers from the Middle East and discuss opportunities, business plans and product features.

Amongst the guests were Prof. Donald Ferguson (Dean European University College - Second from r.t.l) and Dr. Joseph Samy (Assistant Dean European University College - Far right)

Henry Schein together with VIP clients, partners and distributors pose together for the group photo

Dr. Ghassan Nasser - Sales & Marketing Director MEA presenting the welcoming presentation

Mr. George Aalto speaks on the exclusive partners and Suppliers

A complete built clinic including 12 different manufacturers that can supply all the requirements for the daily use of a dental clinic

The Gala Dinner was well attended at the Marriott Marquise Hotel in Dubai (Worlds tallest Hotel)
Unilever unveils scientific data supporting REGENERATE Enamel Science™, the new dental care system proven to reverse the Enamel erosion process

Unique NR-5™ Technology Provides Clinically Proven Superior Enamel Re-Hardening Compared With Fluoride-Only Toothpaste

By Unilever

DUBAI, UAE: 16 February 2015 – New data presented at IADR Cape Town on 26th June, now published in the Journal of Dentistry, demonstrate the efficacy of Unilever’s REGENERATE Enamel Science™, the newly launched dental care system proven to help reverse the early and invisible stages of the enamel erosion process.

REGENERATE Enamel Science™ is the first and only system proven to form hydroxyapatite, with identical composition to underlying enamel minerals. The dental care system, with its unique internationally patented NR-5™ technology, helps recover 82% of enamel hardness after three days of use. A new in situ study shows that the novel technology in REGENERATE Enamel Science™ is effective in the mouth and is able to re-harden enamel significantly better than fluoride-only toothpaste.

Inspired by research on bone repair technology, Unilever Oral Care scientists carried out both in vitro and in situ studies, which proved that calcium silicate can deposit onto sound and eroded enamel. Upon this discovery, the novel NR-5™ technology was developed to augment the natural mineralization processes of human saliva by providing a combination of calcium silicate and sodium phosphate, which help to form a fresh supply of hydroxyapatite that wraps and integrates onto teeth.

Professor Nicola West, Honorary Consultant in Restorative Dentistry (University of Bristol, UK), who was involved in the in vitro research on REGENERATE Enamel Science™ system, says: “Erosive tooth wear by dietary acids is a real dental health issue and a growing problem. Patients are concerned about their teeth, which often results in sensitive teeth. Dentists and patients find erosive tooth wear hard to manage and treatment solutions for it are limited. We now have new scientific evidence, published in high impact dental journals, showing that NR-5™ technology works to remineralise the tooth, and this solution to tooth wear is fast acting and easy to use.”

Speaking about the technology that has been developed through over 9 years of research, Unilever’s oral care researcher who led the team, Fred Schäfer says: “The innovative mechanism of action of the calcium silicate and sodium phosphate in this novel dental care system provides enamel re-hardening that is significantly greater than with fluoride-only toothpaste. This new approach has been proven to help restore acid-challenged enamel.”

The REGENERATE Enamel Science™ system consists of an Advanced Toothpaste for daily brushing and a Boosting Serum (with two custom-fit mouth trays) for application at home, monthly for 3 consecutive days. When used in combination with the daily Advanced Toothpaste, the Boosting Serum increases the Advanced Toothpaste effectiveness by 45%**, enhancing the power of enamel regeneration.

The scientific studies have been published in the June 2014 supplement of the Journal of Dentistry. A link to these studies can be found on the REGENERATE Enamel Science™ website: www.RegenerateNR5.com.

Regenerate Enamel Science™ can be found exclusively at Boots Pharmacy across the UAE from the below prices.
- REGENERATE Enamel Science™ Advanced Toothpaste, AED 190
- REGENERATE Enamel Science™ Boosting Serum, AED 100

References
* Patents granted and pending.
** Based on an in vitro test measuring enamel hardness after 5 days, combined use of toothpaste and serum.

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We provide the broadest selection of relevant products in the industry at the best possible value, to help you run your business more profitably. We stand behind all of our products with a 100% guarantee of satisfaction.
Carestream Dental CS Adapt – Allows users to choose how they want to see their Images

By Ernesto Jaconelli

Carestream Dental CS Adapt is a new processing and software module available for Carestream Dental extraoral systems. The module allows practitioners to optimize image contrast for all 2D panoramic and cephalometric exams according to their diagnostic needs and visual preferences for faster, more accurate diagnoses in any indication.

“What makes CS Adapt unique is its ability to adapt to the user, not the other way around,” said Stéphane Varlet, Product Line Manager, Extraoral Imaging, Carestream Dental. “The software automatically produces optimized images and personalizes their look and feel to the individual needs of the practitioner.”

Users can either define their own preferred image looks or choose from pre-set enhancement filters, resulting in a customized comfort zone for every diagnosis. Up to six pre-set filters—Original, Sharp, Contrast, Dynamic, Smooth and T-Mat film—are available to optimize images. Plus, no manual adjustment is required—preferred looks can be applied by default or assigned to software icons, so practitioners can access them with a single click. CS Adapt capabilities are also available for cephalometric images, along with Carestream Dental’s three popular orthodontic filters that improve image clarity and outline soft tissue.

CS Adapt represents next-generation image processing technology. Using multi-frequency image processing, powerful algorithms deliver impressive image quality and clarity. Images are divided into multiple layers—anatomy, hard and soft tissues, contrast, sharpness, noise—and processed separately to obtain the highest image quality of each layer. The layers are then recombined to reconstruct the final image. An artifact-free filter prevents the creation of dark halos, making clinically relevant details more visible for better and more confident diagnoses.

This intuitive module allows practitioners to easily browse, select and save preferred looks and settings using the CS Adapt Library. The CS Adapt Library features side-by-side image display and real-time changes to facilitate selection and adjustment of the pre-defined looks. Favorite settings can even be saved and applied individually on each workstation or on all workstations at once.

“Regardless of the Carestream Dental equipment practitioners are using, they can achieve consistent, high-quality images across our extraoral solutions,” said Edward Shellard, D.M.D., chief commercial officer for Carestream Dental. “CS Adapt integrates with any new Carestream Dental extraoral system and is available as a simple software upgrade for all previously installed extraoral equipment.”

CS Adapt will also be available as a module for the RVG 6200 sensor.

*excludes the 8000/8000C and 9500

For more information about the CS Adapt module, or any of Carestream Dental’s extraoral solutions, please call our Carestream Dental Dubai Office on +9714 48 77 965 or visit www.carestreamdental.com

Visit our Stand at: THE CAD/CAM & DIGITAL DENTISTRY INTERNATIONAL CONFERENCE, DUBAI ON 08-09 MAY 2015

Visit www.carestreamdental.com/solutions or call 800.944.6365.

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Inman Aligner and Intelligent Alignment Systems are pleased to announce our annual symposium. Following a superb 2014 meeting in Copenhagen our 2015 venue is DUBAI! We have a world renowned line-up of speakers.

We have secured fantastic room rates at the exclusive Jumeirah Beach Hotel during peak season Only 900 AED (£160 / €216 / $245) + tax

We are also pleased to share the venue in a joint meeting with the 7th Dental - Facial Cosmetic International Conference (DFCIC) so those wanting to combine some winter sun with even more superb CPD can combine both meetings.

IAS Symposium
Who for All Inman and CAPP delegates
Cost Before July 15 AED 1100 / £197 / $300
Summary This day is designed to deliver a condensed wealth of information and motivation to grow your cosmetic practice. CAPP and Intelligent Alignment Systems have worked together to bring a highly respected team of dentists from all over Europe!

Dr Tif Qureshi
(Past President British Academy Cosmetic Dentistry)
Current trends in Anterior Aesthetic Orthodontics! Interceptive Occlusal Dentistry - the new path for dentistry

Dr James Russell
(Accredited by British Academy Cosmetic Dentistry)
GDP Orthodontic pre-alignment prior to composite bonding and veneers - a technique case study

Dr Jason Smithson
(Global authority on composite artistry)
Emulating natures morphology with direct composite

Dr Jens Nolte
(Private Dentist and lead IAS trainer in Germany)
Creating the dream aesthetic practice

Dr Andy Wallace
(Vice President of European Society of Aesthetic Orthodontics)
Why EVERY Dentist should offer simple orthodontics!

Dr Richard Field
(Young Private Dentist of the Year 2014)
Essential Dental Photography - made exquisite

Dr Charlotte Nyby
(President of New Holistic Dentistry - Denmark)
Using the Alignment - Bleaching - Bonding Protocol to make dentistry more profitable and more fun with less stress

Inman Aligner Update Course
Who for Certified Inman Aligner Dentists
Cost Before July 15 AED 600 / £108 / $163
Summary The 2015 installment of the highly rated update course. A day packed or the latest tips and techniques to boost your Inman Aligner treatments.

7th Dental - Facial Cosmetic International
Who for All Dentists
Cost Before July 15 AED 1000 / £179 / $272
Summary This very popular conference regularly has over 1000 delegates. A wide range of lectures, all in one room means delegates can enjoy multiple topics without needing to decide what to listen to. Many of the Inman Trainers have spoken at and attended this conference. More information about speakers at: www.cappmea.com/aesthetic2015/speakers.html

Inman Aligner Certification Course
Who for All Dentists
Cost Before July 15 AED 2400 / £429 / $654
Summary This is the required course to become a provider of the Inman Aligner orthodontic appliance. This hugely popular and highly rated course has been running for over 7 years all over the world.

Inman Aligner Advanced Course
Who for Certified Inman Aligner Dentists
Cost Before July 15 AED 2200 / £393 / $599
Summary This course, run by Tif Qureshi, is designed to allow experienced Inman Aligner users to treat more complex cases with confidence. We recommend that dentists have completed at least 10 cases to make sure they benefit from this training. More Information at www.inmanalignertraining.com
FKG Dentaire: a new era in Endodontics

By FKG

Following the success of last year, FKG Dentaire has created a dedicated space on its booth for free Workshops. The demand was extremely high and most of the available spaces were booked for all AEEDC on day one. Should anyone be interested to attend such workshops on FKG Dentaire instruments and materials, free trainings are available in FKG Dentaire Dubai Training center (information and booking: mea@fkg.ch).

Dr Guillaume Jouanny (University of Pennsylvania, USA) and Pr Roger Rebeiz (Dental College, Lebanon) Lectures and Workshops on Rotary and latest generations of Bio ceramics Sealers and Root Repair Materials (Race and TotalFill) were outstanding. This success proves once again that the tendency in Endodontics is toward a more conservative and biologic approach. Race files (over 120 different sizes, length and tapers available) in addition of being non screwing compare to other systems on the market allows dentists to increase the size of their treatments apically respecting the root anatomy avoiding over enlargements.

The Root Canal Anatomy not being round, the files available today on the market leave untreated areas ranged from 59.6% to 79.9% (F. Paqué, et al JOE 2010;36 (4):703-707) Following this observation, over the last years FKG Team and some worldwide known dentists and endodontists have been working hard on finding a way to increase treatment quality and success rate by creating a new generation of files. Thought out of the box, they will increase dramatically the areas treated, respecting the roots anatomy by adapting their shape to it while preserving dentine!

The Xpendo file will be launch at IDS 2015 in Germany, on FKG Dentaire booth (Hall 4.2, Stand G28/J29).

Pr. Roger Rebeiz providing hands-on courses at the FKG booth at the trade show

The Swiss Pavilion was again largely visited A sneak peak of FKG workshops on Endodontics. FKG recently opened their showroom in JLT in Dubai, UAE

3D efficiency - optimal cleaning while preserving dentine

FKG Dentaire SA
www.fkg.ch
AAA - After Appointment Action

By Dr. Ehab Heikal

A very typical frustration for many dentists is to have cancelled appointments. And I have discussed in another section of my book, that such cases should be punished in case of no show.

However; the coercive action of punishment is a tool to minimize such incidents, so it is not the aim. Especially that, in some cases, you cannot punish the patient if the appointment is cancelled early enough.

And my concern now is not regarding your clients or existing patients, I am concerned now with your new patients that have never been treated at your office before.

So what happens between the time of appointment setting and the time of cancellation?

The simplest thing is that the patients could get busy, and since they will not consider the dental treatment as a priority compared to whatever came up and they have to do. They will find no motive preventing them from re-scheduling or cancelling the appointment. ‘I have too many things to do today—I’ll just cancel my appointment.”

What also helps is that a dental appointment is not a pleasant one for many reasons you know. Also they might be attracted to another dentist through word of mouth. For example, Sally was discussing with her friends the treatment plan she is planning to perform at your clinic, or the filling she is about to have, and of course the fear of pain will be a major player in the discussion, so Susan suggests that Sally goes to her (Susan’s) dentist as she has never felt any pain at his clinic. Here we have a shift through an opinion leader for Sally based on the motive of avoidance of pain.

Or consider this patient thinking:

“I should be going back to my old dentist—he wasn’t great, but I knew him. Why am I changing?”

Here the fear of change is the motive. Or the theory of: the bad I know is better than the good I don’t know!!!

I can list hundreds of examples, but that is not my point. My aim is to assist you in overcoming those complications.

We have to set a motive and help the patient by throwing the rope and pulling him/her to our clinic.

You need to make it easier for your patient to mentally confirm the appointment, and to eliminate the hesitation barrier.

The Professional New Patient Kit

There is one simple way; you need to create a Professional New Patient Kit. This could be an electronic kit for internet and computer users, or a hard copy kit that you can send via any local courier in town.

You need to send this kit out the same day you set the appointment.

The kit is composed of a brochure—an appointment card—even a welcome letter—plus a complimentary copy of your newsletter. Effectively, each piece responds to a different unasked question, building confidence and commitment on the spot!

How the components work together

The Welcome Letter is a conversational greeting between you and your new patient—the equivalent of eye contact and a handshake.

The Welcome Brochure introduces you and your practice. It outlines your clinical credibility, maps your location, lists your services. And, most important, answers the unasked questions: Will you understand my fears? Can you protect me from communicable diseases? How will you handle my emergency?

The Appointment Card confirms date and time—subconsciously strengthening resolve to keep the appointment.

Your Clinic Newsletter demonstrates your commitment to informative communication with every patient.

Research shows that going to the dentist is very low on the list of things people like to do. One of the key reservations is fear of the unknown. The worst part of this factor is that most people are too embarrassed to ask questions. Your brochure should answer the questions so there’s no need for people to be fearful.

The Welcome Brochure answers them for you automatically—before the very first appointment! The way is paved, and that tenuous connection between you and the first-timer grows to a positive commitment.

Contact Information

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Interview: “This is the only pain management tool that instills a sense of mastery”

By Anne Faulmann, DT

Visits to the doctor can be a distressing experience, especially for children. Procedures that are likely to involve pain, such as vaccinations, blood tests and dental interventions, are stressful for young patients, their parents, physicians and nurses. In order to help children cope with pain and to make visits to the dentist and doctor a more pleasant experience generally, a team of researchers at the University of Calgary have developed MEDi, an innovative robotic pain management tool.

Dental Tribune Online spoke with Dr. Tanya Beran, Professor at the Cumming School of Medicine at the university and Founder and Chief Scientific Officer of RxRobots, where MEDi was invented.

Dental Tribune Online: Dr. Beran, how did you come up with the idea for a medical robot to help children cope with pain?

Dr. Tanya Beran: At a child development conference, I saw a video of a teenage boy interacting with a robot. Not only did he show empathy, but he also tried to help the robot. I could not understand why and there was almost nothing in the research. So I started my own, I was surprised to find that children and teenagers tend to think that robots are alive. Now, while working at a children’s hospital, I found it alarming to watch children screaming, struggling, and pleading not to have a needle. I realized that medical procedures need to be easier, faster and far less painful. Then I put two and two together. I thought maybe children would respond to a friendly robot to help them deal with pain.

Could you please explain how MEDi works and what kind of tasks it performs?

We program MEDi with cognitive-behavioral interventions that research shows do work. Some of these include instructions to take deep breaths to relax the muscles, framing (replacing a negative thought with a positive one), and positive reinforcement (the robot providing a reward). When we teach coping strategies to children, they tend to forget to use them. When we teach them to parents, they tend to use them ineffectively and may even exacerbate children’s anxiety. For example, telling a child that it will be ok can make them angry because to them it is not really true. However, the robot is able to effectively deliver the interventions every time.

Why is MEDi a useful tool during medical procedures, especially for children?

The robot is endeavoring to children and has life-like movements. It provides both distraction and pain coaching. MEDi encourages children so they can develop a sense of mastery to deal with the procedure that they can then transfer to other procedures. For example, one mother shared with us that, as a result of her daughter having a blood test with MEDi, for the very first time afterwards, she started talking with her oncologist. The mother believed that this confidence to speak up for herself was due to the positive support her daughter received from MEDi. This is the only pain management tool that instills a sense of mastery.

How can MEDi be of use during dental procedures?

As with any medical procedure, such as vaccinations and blood tests, MEDi can provide the same support during dental procedures that involve a needle. In addition, children have anxiety and fear about medical procedures that are not painful, like having a radiograph taken or an EEG test. MEDi can also work for dental procedures that are not painful to calm nerves, provide comfort, and distract children from negative thoughts and feelings. Our research showed that MEDi increased cooperation from children so the procedures could be completed more quickly and with greater satisfaction from children and their parents.

Has MEDi already been applied successfully in dental practices or have there been any tests regarding MEDi’s effectiveness during dental procedures?

We are looking for a partner in dental practice who would like to bring MEDi in to work with their patients. From our randomized controlled trials, we have evidence that MEDi reduces pain and distress, and we expect to find similar results for other procedures, including dental ones. MEDi attracts patients to clinics. One family drove 60 km for their son to be vaccinated with MEDi, so there could be a competitive advantage for dental clinics as well. Several parents have asked us to create applications for MEDi in dentistry.

MEDi has been developed and tested in Canada. Do you think that it would work in other countries with a different cultural background as well?

MEDi can be programmed with a variety of behaviors and can speak in 20 languages. The words and actions can be selected to be culturally appropriate and highly engaging for children of all ages and developmental abilities. The robot is only limited by our imagination on how to program it!

Contact details available from the publisher ▲

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In the centre of attention – How to run a patient centered dental clinic

By Eniko Simon

During any work advising dental practices, many practice owners come to the conclusion that patients do not return for treatment. It is a common problem in any dental business. In this article I wish to share some tips on how to reduce these problems and explain how could a patient centered clinic management approach enhance patient journey and aid the success of a dental business.

Treatment Acceptance

Whenever we decide to buy a product or service we do it for one simple reason; we decide to buy it as it offers a solution for our problem. You, as a dentist, have to be the best advocate of the procedure you are offering. You should know your patients in order to convince them about the necessity of the treatment. They have to understand what is causing the concern.

New patient consultation

The first consultation with the treatment coordinator is an informal chat between the patient and your treatment coordinator (TCO) when the TCO asks questions to find out the dental concerns of the patient and introduces the clinic to the patient. It is the first step to build rapport and make the patient feel comfortable in your clinic.

Patient care management

The consultation should be free and not have any effect on the outcome. This is very important, as the patient should be in control about what they want and how much they want to invest in any procedure.

The TCO

The treatment coordinator role has grown steadily in the US and UK in the past 10 years. The treatment coordinator is not only there to assist the dentist in preparing and presenting the treatment plan but also increasing the treatment conversion by providing an enhanced patient journey / patient experience in the dental clinic.

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Preparing for the worst

By Fiona Stuart-Wilson

Each year some practices have to deal with an emergency – not a medical emergency but a business emergency. Although most of us would buy insurance, we do so on the basis that we hope that the risks we are insuring our practices against will never actually happen. Of course the likelihood of the sort of risk occurring which would affect our ability to operate as a dental practice is low but there is no getting away from the fact that the unexpected does happen, and insurance is really a necessity for you to continue to operate, keep patients happy, pay the staff and earn some money yourself. Disasters can take a long time to recover from and patients need to be seen and cared for during this time. All this means that a practice should always have a plan should disaster strike. You might think that this sort of thing could never happen to your practice but it could.

Your practice should have a business continuity to enable it to continue to function and survive a disaster, so here are some things every dentist and manager should consider.

1. What could go wrong?

Disasters by their very nature are usually unexpected but that does not mean we should not try to forecast some of the greater risks that we face.

Think through some of the risks to your practice and what these might mean for the practice. This could include accidents such as fire, natural disaster, loss of key members of staff or crime.

2. How safe is practice property?

Make sure your practice is as prepared as it can be to receive a disaster. Carry out a regular check on how secure your building is, building equipment, computer systems, records and website are.

For instance how many people have access to the burglar alarm code or keys? How often is the code changed? Are valuable documents such as client files kept in a safe, locked away in a filing cabinet or left in a desk drawer?

If you haven’t already, consider photographing all of your valuables and equipment for insurance purposes and copies of key documents such as insurance policy. Make sure these are in a safe place that more than one trusted person knows about.

3. Where else could we work from?

If disaster strikes your patients usually prefer to go to care and you still need to run your dental services. You should have arrangements in place now for an alternative location to treat patients or at least send them to in the event that you cannot see them in your own practice.

It’s not just the clinical side of things either. You also need to think about where you will carry on with non-clinical aspects of your practice, such as contacting patients, arranging or cancelling appointments, administration, and paying bills and staff.

This might of course be your home but if your information and data are not on the Cloud, make sure your backup operations site has critical equipment and data (computer, telephone, headed paper, back-ups etc) and essential information such as contact details and copies of passwords are also accessible. If you know what your backup system consists of, it is also a good idea to make sure that you and at least one other key person has this information. After all, disaster could strike whilst you are on holiday on the other side of the world.

4. Do our staff know what to do?

Do make sure that your team knows what you expect of them in the event of an emergency. If not, make sure you get a copy of your business continuity plan is and when and where they should relocate to work in the event of an emergency.

5. How will we pay the bills and keep going?

If you have a backup plan you will still need to pay the bills. If you have a disaster plan in place then you should be able to keep going. If you have to leave them in a lurch, try the practice cheque book, credit cards and keep enough cash on hand to meet emergency cash flow needs.

6. How will we tell the patients?

You will need to let your patients know quickly in the event of an emergency or disaster, as they need to be reassured, told what to do and where to go. Make sure for example you have an arrangement in place with your website provider so that they can put this information on the home page of the website as quickly as possible. Save time later by writing that information copy now! It should include your emergency contact information, details of your backup surgery premises, and what to do about appointments. You can also use social media to get the word out about your emergency arrangements.

About the Author

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38 PRACTICE MANAGEMENT
Over 60 percent of general dentists perform dental implant procedures

By Dental Tribune International

BIRMINGHAM, Ala., USA: Today, general dentists in the U.S. and other parts of the world provide a comprehensive range of services. However, there has been only limited research on which specific procedures are performed most commonly by this group. Now, a new study has shown that non-implant restorative treatments, esthetic procedures, and extractions are routinely performed by the majority of general dentists. Over 60 percent also provide implant treatments.

In order to determine the ten most commonly performed dental procedures, data from 2,367 general dentists in the U.S. National Dental Practice-Based Research Network were collected via a questionnaire.

The majority of participants stated that they perform non-implant restorative treatments (96 percent), esthetic procedures (59 percent), and extractions (64 percent) on a regular basis. Almost 60 percent said that they also perform endodontic therapy. While orthodontic treatments and periodontal surgery were not common among two-thirds of the participants, over 60 percent stated that they perform dental implant procedures occasionally or routinely.

The study also found that more male dentists performed endodontic procedures, implant treatments and surgical periodontal therapy than did their female counterparts.

As a considerable number of general dentists interviewed reported performing at least some endodontic procedures and periodontal surgery, it is possible that provision of such services is a means for general dentists to adapt to the availability of dental specialists and to overall demand for services in their practices, the researchers said.

“These findings may have implications for how general dentists respond to the changing picture of dental economics...”

The study, titled “Provision of Specific Dental Procedures by General Dentists in the National Dental Practice-Based Research Network: Questionnaire Findings,” was published online on Jan. 22 in the BMC Oral Health journal. It was conducted by researchers at the University of Alabama at Birmingham in collaboration with other scientific research institutions throughout the U.S.
KaVo donates dental treatment unit to UNESCO village in Sri Lanka

By Dental Tribune International

A hungalla & Kosgoda, Sri Lanka: Recently, KaVo Dental, an international manufacturer of dental instruments, equipment and imaging technology, donated one of its dental treatment units to a development aid project in Sri Lanka. Through the donation, people living in the UNESCO village south-west of Sri Lanka will have access to dental treatment in the future.

“KaVo has now donated a dental treatment unit to the village, where 34 families live.”

On 26 December 2004, large parts of Indonesia were struck by an Indian Ocean earthquake that resulted in a tsunami. The plight of the affected countries, including Sri Lanka, India, Thailand and Somalia, prompted a worldwide humanitarian response. Ahungalla and Kosgoda, two communities in the south-west of Sri Lanka, were very hard hit: 200 people lost their lives and about 400 houses were destroyed. Shortly after the catastrophe, German charity organisation Future for Children helped build a UNESCO village within a few months.

KaVo has now donated a dental treatment unit to the village, where 54 families live. The second ESTETICA Comfort 1005 unit was completely refurbished by the company’s service team. In December 2014, monk Winnaladhanna Tissa Nayaka from the UNESCO village and Elfriede Süß, the contact person for Future for Children in Sri Lanka, visited KaVo’s production site in Germany. The unit will be installed shortly by KaVo’s distributor Pluradent.

BEGO celebrates 125th anniversary

By Dental Tribune International

BreMEN/CoLongoNe, Germany: BEGO, a German-based provider of dental equipment and materials, has announced the launch of the “Building the Future for 125 Years—Happy Birthday BEGO!” campaign in celebration of its 125th anniversary. To kick off a year of celebrations, the company will unveil its new 3-D printer, Varseo, at the upcoming International Dental Show (IDS) in Cologne.

“2015 is set to be a very special year...”

In Cologne, the company will be introducing its latest self-developed 3-D printing system to the public. Varseo is optimised for dental applications and allows for the production of a wide range of plastic items in the laboratory. In addition to the printer, associated materials, software-tools and services, such as splints, surgical guides, CAD/Cam partial denture frames and customised impression trays, will be on display.

BEGO was founded in 1890 by Dr William Herbst in Bremen. Today, the family-run company has an international workforce of approximately 450 in its BEGO Dental, BEGO Medical and BEGO Implant Systems divisions.
This morning your patient just washed away an important sign of gum disease

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References:

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“Smile for life” campaign: FDI encourages people to limit sugar intake

By Dental Tribune International

GENEVA, Switzerland: As World Oral Health Day (WOHD) 2015 approaches, FDI World Dental Federation advises people to consider the impact of frequent sugar consumption on their smile for life. Dental caries is the most common non-communicable disease in the world, and research has demonstrated that sugars are the main cause of tooth decay.

When one eats or drinks something sugary, the bacteria in the plaque feeds on the sugar and releases acid that attacks teeth for about one hour. Frequent consumption of sugar results in prolonged acid attacks, weakening the protective outer layer of the teeth.

Speaking about this process, Dr Jaime Edelson, chairperson of the FDI WOHD task team, commented: “Sugar reacts with bacteria in the mouth, which together form an acid that damages the enamel. When this keeps happening, a hole is formed in the tooth, which then requires filling and may over time lead to an extraction. By paying close attention to how often we are consuming sugary foods and drinks, the number of acid attacks on our teeth can be reduced.”

WOHD is an opportunity for the FDI to draw attention to proven oral care behaviours that people can adopt to protect their teeth—for life. These include brushing twice a day with a fluoride toothpaste, cutting down on consumption of sugary foods and drinks between meals, and chewing sugar-free gum after meals and snacks when on the go and brushing is not feasible.

FDI President Dr Tin Chun Wong commented, the theme of “World Oral Health Day 2015, ‘Smile for life’, has a double meaning—lifelong smile and celebrating life. Smiling implies self-confidence and having fun, as people only smile if they are happy and have a healthy life. Please take the time to consider your oral health and bring a smile to everyone around you.”

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www.fdi2015bangkok.org
www.fdiworlddental.org

The Royal Technology Mission visit was organised by the Royal Swedish Academy of Engineering Sciences. The academy has organised similar excursions around the world since 1984. In addition to His Majesty, the mission is formed by business executives and other influential figures from Sweden’s private and public sectors.